

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1093

CERTIFICATE OF DEATH

(1080)

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville (2 yrs)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown (lifetime)									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walraven Nursing Home		d. STREET ADDRESS Washington Ave 147X-2									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month 1 Day 31 Year 1961									
3. NAME OF DECEASED (Type or print) Anthony V.		4. DATE OF DEATH									
5. SEX male white		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/4/1883							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland							
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Anthony Bell		14. MOTHER'S MAIDEN NAME Geraldine Phillips							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-09-3968		17. INFORMANT Mrs. Harry Truitt ^{Address} Beliefonte Wilmington, Dela.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		19. INTERVAL BETWEEN ONSET AND DEATH <i>Cerebral Hemorrhage</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21. I certify that (I) (this hospital) attended the deceased from <u>June 25, 1969</u> to <u>Jan 31, 1964</u> , that (I) (we) last saw the deceased alive on <u>Jan 30, 1964</u> , and that death occurred <u>6/24/64</u> , from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
22a. SIGNATURE <i>C. H. Metcalf</i>		22b. DATE SIGNED 1/31/61		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
22c. PHYSICIAN'S NAME (Type) C. H. Metcalf		22d. ADDRESS Sudlersville, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/2/61		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul Cem.		23d. LOCATION (City, town, or county) (State) near - Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Willis Wells</i>		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE FEB 6 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10-11

1948-1950

1951

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1094 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

61085

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Queen Ann's</i> MARYLAND		a. STATE <i>Maryland</i> b. COUNTY <i>Queen Ann's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deerfield - Centreville</i> Md.		c. LENGTH OF STAY IN 1b <i>6 mo</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Centreville</i>	

3. NAME OF DECEASED (Type or print)		First <i>Samuel</i>	Middle <i>Bolard</i>	Last	4. DATE OF DEATH	Month <i>JAN</i>	Day <i>5</i>	Year <i>61</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 4 1914</i>	9. AGE (In years last birthday) yrs. <i>47</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Unknown</i>	12. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>
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13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>State Police</i> Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>199.01</i> DUE TO <i>Hemorrhage Massive</i>		<i>10 min</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Sarcoma of Neck</i>		
DUE TO (c)		<i>6 mo</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
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20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>C. R. Lupton</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>Jan 7, 1961</i>
EXAMINER'S NAME (Type) <i>C. R. Lupton</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>JAN. 10</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>CHURCH HILL</i>	22d. LOCATION (City, town, or county) <i>CHURCH HILL</i> (State) <i>MD.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Hane</i>	ADDRESS <i>Church Hill, Md.</i>	24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
		DATE <i>JAN 13 '61</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1095

CERTIFICATE OF DEATH

Reg. Dist. No. 61082

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sudlersville		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sudlersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Emma		First May	Middle Clow
4. DATE OF DEATH January 25, 1961		Month January	Day 25
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH February 7, 1905		9. AGE (In years lost birthday) 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William G. Jackson		14. MOTHER'S MAIDEN NAME Janie Ware	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. J. Omer Clow, Sudlersville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tid		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 1960, to <u>Jan 25</u> , 1961, that I last saw the deceased alive on <u>Jan 25</u> , 1961, and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. <u>@ W. Metcalfe</u> Sudlersville, Md. DATE SIGNED <u>1/27/61</u>	
ACTUAL SIGNATURE C. H. Metcalfe		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1961	22c. NAME OF CEMETERY OR CREMATORIUM Sudlersville Cemetery
22d. LOCATION (City, town, or county) Sudlersville		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Wellington, Md.		24a. REC'D BY REGISTRAR DATE JAN 30 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1096

CERTIFICATE OF DEATH

Reg. Dist. No. 11083

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Sudlersville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Sudlersville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Pauline	Middle Elizabeth	Last Faulkner	4. DATE OF DEATH	Month January	Day 29	Year 1961
5. SEX Fem		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17-1910		9. AGE (In years lost birthday) 51 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Thomas E. Lowman			14. MOTHER'S MAIDEN NAME Laura Everett			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			INFORMANT Address Mrs. George D. Bostic--Church Hill, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 22. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) (d) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21. I certify that I attended the deceased from Jan. 24, 1961, to Jan. 29, 1961, that I last saw the deceased alive on Jan. 25, 1961, and that death occurred at 7 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Sudlersville, Md. DATE SIGNED ACTUAL SIGNATURE C. H. Metcalfe 1/31/61								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 1		22c. NAME OF CEMETERY OR CREMATORIUM Church Hill		22d. LOCATION (City, town, or county) (State) Church Hill, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR DATE FEB 2 '61		24b. REGISTRAR'S SIGNATURE Clarence S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
109 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 61084

1		TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your information.									
2		TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.									
3		1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND									
4		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Millington		c. LENGTH OF STAY IN 1b 4-7c		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE Maryland		b. COUNTY Queen Anne's			
5		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Millington		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
6		3. NAME OF DECEASED (Type or print) James Henry Gross		First Middle Last		4. DATE OF DEATH Jan 28		Month Day Year			
7		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25 1890		9. AGE (in years last birthday) 70 yrs.	
10		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY SERVICE STATION		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A			
11		13. FATHER'S NAME William Gross		14. MOTHER'S MAIDEN NAME Sarah Katherine Mannerling							
12		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs Carrie E Teet		Address Millington, Md.			
13		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
14		<p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Force Head - Self Infected DUE TO (c) None</p>									
15		<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)</p> <p>Diabetic, Cardiac, Depression</p>									
16		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
17		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Shot self with 43 c Revolver		20c. TIME OF INJURY Month Day Year Hour a. m. Jan 28 p. m. 12-12-1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
18		20f. (City or town) Millington Q.A. Maryland		(County) (State)							
19		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
20		ACTUAL SIGNATURE C. R. Layton		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan 28, 1961	
21		EXAMINER'S NAME (Type)		22b. DATE THEREOF Jan. 31, 1961		22c. NAME OF CEMETERY OR CREMATORIUM Millington Cemetery		22d. LOCATION (City, town, or county) Millington, Kent Co; Md.		(State)	
22		23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.		ADDRESS		24a. REC'D. BY REGISTRAR FEB 1 1961		24b. REGISTRAR'S SIGNATURE Charles S. Kraus			
23						DATE					

DEPARTMENT OF PUBLIC SAFETY - DIVISION OF POLICE
CERTIFICATE OF EXAMINATION OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1098

CERTIFICATE OF DEATH

Reg. Dist. No.

61085

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Spencer C		4. DATE OF DEATH Month January Day 18 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 5-1899	
WIDOWED <input type="checkbox"/>		9. AGE (In years lost birthday) 61 yrs.	
DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman	
11. KIND OF BUSINESS OR INDUSTRY		12. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William H. Hammond		14. MOTHER'S MAIDEN NAME Martha Gooding	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address Mrs. Hammond--Centreville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Occlusion -</u> DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) <u>Cerebral Thrombosis</u> DUE TO			
(c) <u>Arteriosclerosis, Cerebral, Generalized</u> DUE TO			
INTERVAL BETWEEN ONSET AND DEATH 15 mins.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to Jan. 18, 1961, that I last saw the deceased alive on Jan. 16, 1960, and that death occurred at 11:15 A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED John R. Smith, Jr. 1/21/61			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) John R. Smith, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Jan. 21	
22c. NAME OF CEMETERY OR CREMATORIAL ODD FELLOWS		22d. LOCATION (City, town, or county) SEAFORD DEL.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Lane Church Hill, Md.		24a. REC'D BY REGISTRAR DATE JAN 24 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

47/36 50 114 2000

8201

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1099

CERTIFICATE OF DEATH

Reg. Dist. No. 61086

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Queen Anne	
Queen Anne				c. LENGTH OF STAY IN lb		Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural - Stevensville		86		Rural - Stevensville		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Martha		Middle Heath		4. DATE OF DEATH		Month January		Day 10 Year 1961	
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 25, 1874		9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Turner		14. MOTHER'S MAIDEN NAME Mary Hazelton									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Conley		Address S-Stevensville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH					
332X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Generalized Arteriosclerosis							
(b)		DUE TO									
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Gangrene of left foot				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Jan 5, 1961, to Jan 10, 1961, that I last saw the deceased alive on Jan 5, 1961, and that death occurred at M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE Irvin G. Hoyt, M.D.						DATE SIGNED					
PHYSICIAN'S NAME (Type) Irvin G. Hoyt, M.D.		Queenstown, Maryland		1/12/61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-13-61		22c. NAME OF CEMETERY OR CREMATORIAL Stevensville, Com.		22d. LOCATION (City, town, or county) Stevensville, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE James D. O'Donnell		ADDRESS Poston, Md.		24a. REC'D BY REGISTRAR JAN 16 '61		24b. REGISTRAR'S SIGNATURE Charles S. Kraus					

TO HOSPITAL
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
1100 CERTIFICATE OF DEATH					Reg. Dist. No. 61087						
1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sudlersville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sudlersville						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First John	Middle G.	Last Jerling	4. DATE OF DEATH January 20, 1961		Month	Day	Year		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1879		9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance work		10b. KIND OF BUSINESS OR INDUSTRY Nat. Gypsum Co.		11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Paul Jerling					14. MOTHER'S MAIDEN NAME Lovisa Hanson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 144-12-0854		INFORMANT Mrs. Eleanore C. Jerling, Sudlersville, Md.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac Embolism</u> DUE TO <u>260x</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ulcer L. Foot</u> DUE TO <u>9 mos</u> (c) <u>Diabetes mellitus</u> DUE TO <u>Year</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month o. m. 19 Hour p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
21. I certify that I attended the deceased from <u>Dec. 23</u> , 1959, to <u>Jan 20, 1961</u> , that I last saw the deceased alive on <u>Dec. 23</u> , 1959, and that death occurred at <u>538</u> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>H H Hamilton</u>					ADDRESS (Street, city or town, state) <u>Wilmington, Md.</u>						
					DATE SIGNED <u>1/23/61</u>						
PHYSICIAN'S NAME (Type) Dr. Harry H. Hamilton											
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Jan. 24, 1961		22c. NAME OF CEMETERY OR CREMATORIAL Silverbrook Crematory		22d. LOCATION (City, town, or county)		(State) Del.			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows, Wilmington, Md.</u>					ADDRESS <u>Arthur S. Kraus</u> 24a. REC'D BY REGISTRAR DATE JAN 24 '61 24b. REGISTRAR'S SIGNATURE						
VS A15 (4) 1SM 9/58											

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

110:

CERTIFICATE OF DEATH

Reg. Dist. No. 61088

TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Chester</i>		c. LENGTH OF STAY IN lb <i>65 yr.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Q. A.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box A</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Chester</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Andrew James Johnson</i>		First	Middle	Last	4. DATE OF DEATH Month <i>Jan.</i>	Day <i>24</i>	Year <i>1961</i>		
S. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 25 1895</i>	9. AGE (In years last birthday) <i>65 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Oyster Shucker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Seafood</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Gilbert Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i>216-08-0104</i>		17. INFORMANT <i>Son Johnson, Chester, Md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		DUE TO <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		(b) <i>Hypertension</i>		? yrs					
DUE TO <i></i>		(c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Queenstown, Md.</i>	(County) <i></i>	(State) <i></i>	
21. I certify that I attended the deceased from <i>Aug.</i> 1961, to <i>Jan.</i> 1961, that I last saw the deceased alive on <i>Jan. 11, 1961</i> , and that death occurred at <i>433 M.</i> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>Queenstown, Md.</i>									
DATE SIGNED <i>1/14/61</i>									
ACTUAL SIGNATURE <i>Irvin G. Hoyt</i>									
PHYSICIAN'S NAME (Type) <i>Irvin G. Hoyt MD</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-29-61</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Chest Cem</i>		22d. LOCATION (City, town, or county) <i>Chest</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Washell, Porters, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>FEB 1 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>				

TO HOSPITAL may be referred by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 1102 CERTIFICATE OF DEATH

Reg. Dist. No. 61089

1. PLACE OF DEATH o. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Del.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barclay		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wyoming	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Starkey Nursing Home		d. STREET ADDRESS 46X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary	First Mary	Middle Cooper	Last Jolls
4. DATE OF DEATH January 1, 1961	Month January	Day 1	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 29, 1871
9. AGE (In years lost birthday) 89	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel Cooper		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT Mrs. Ralph Graham,	Address Sudlersville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral vascular disease General asthenia Senility			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) W			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 12 p. m. 12 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1, 1961 to Jan 1, 1961 that I last saw the deceased alive on Dec 30, 1960 , and that death occurred at 11:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. H. Metcalfe	ADDRESS (Street, city or town, state) Sudlersville, Md.	DATE SIGNED Jan 13/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 4, 1961	22c. NAME OF CEMETERY OR CREMATORIUM Odd Fellows Cemetery	22d. LOCATION (City, town, or county) Camden,
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Wellington, Md.	ADDRESS Arthur S. Krause	24a. REC'D BY REGISTRAR DATE JAN 5 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retorted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1103

CERTIFICATE OF DEATH

Reg. Dist. No. 61096

1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington		b. COUNTY Queen Anne	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Gertrude		4. DATE OF DEATH Last Month Day Year Leach January 27, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Nicklas		14. MOTHER'S MAIDEN NAME Gertrude Rosenberger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 218-09-9035	
17. INFORMANT Chester Leach, Husband.		Address Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema, cerebral</u> DUE TO <u>260X</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Degeneration of the heart muscle</u> DUE TO <u>10 years</u>			
(c) <u>Diabetes mellitus</u> DUE TO <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 7, 1961</u> to <u>Jan 27, 1961</u> , that I last saw the deceased alive on <u>Jan 27, 1961</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agnes Krulewski</i>		ADDRESS (Street, city or town, state) <u>Millington, Md.</u> DATE SIGNED <u>Jan 28, 1961</u>	
PHYSICIAN'S NAME (Type) <i>GEZA KORALEWSKI</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 31, 1961	
22c. NAME OF CEMETERY OR CREMATORIUM Townsend Cemetery		22d. LOCATION (City, town, or county) Townsend, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellows</i>		ADDRESS <i>Millington, Md.</i>	
24a. REC'D BY REGISTRAR FEB 1 '61		24b. REGISTRAR'S SIGNATURE <i>Arthurs & Trahan</i>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1104 CERTIFICATE OF DEATH

Reg. Dist. No. 61091

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Georgesville</i>		b. COUNTY <i>Queen Anne's</i>	
c. LENGTH OF STAY IN 1b <i>6 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X St. Georgesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>LEWIS ADDISON MASON</i>		4. DATE OF DEATH Month <i>JAN</i> Day <i>24</i> Year <i>1961</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 23 - 1887</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fishing & Saling</i>	
11. BIRTHPLACE (State or foreign country) <i>St. Georgesville Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William H. Mason</i>		14. MOTHER'S MAIDEN NAME <i>Sara J. Merchant</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-16-7246</i>	
17. INFORMANT <i>Mrs. Eddie Mason Stevensville Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163X</i> DUE TO <i>Carcinoma of the lung right lower lobe</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>inoperable</i> DUE TO <i></i> (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>about 8 to 10 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Right inguinal hernia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>St. Georgesville</i>		20f. (City or town) <i>St. Georgesville</i> (County) <i>St. Georgesville</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>November 17, 1960</i> to <i>Jan. 24, 1961</i> , that I last saw the deceased alive on <i>January 23, 1961</i> , and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Stevensville Maryland</i> DATE SIGNED <i>January 24, 1961</i>	
ACTUAL SIGNATURE <i>Theodor Sattelmayer, M.D.</i>		PHYSICIAN'S NAME (Type) <i>Theodor SATTELMAYER, M.D. Stevensville Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 26 - 61</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Chestertown</i>		22d. LOCATION (City, town, or county) (State) <i>Chestertown Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Wood Butler, Butler Bros.</i>		ADDRESS <i>Chestertown Md.</i>	
24a. REC'D. BY REGISTRAR <i>FEB 1 1961</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knott</i>	
DATE <i></i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1105 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 61092

1. PLACE OF DEATH a. COUNTY <i>R. A.</i>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester</i>	c. LENGTH OF STAY IN 1b <i>3 yr.</i>	b. COUNTY <i>Q. A.</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <i>Lillian</i>	Middle <i>Virginia</i>	Last <i>Mead.</i>	4. DATE OF DEATH Month <i>Jan.</i> Day <i>28</i> Year <i>1961</i>
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5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 24, 1892</i>	9. AGE (In years last birthday) <i>69 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
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13. FATHER'S NAME <i>Walter B. Durham</i>	14. MOTHER'S MAIDEN NAME <i>Alice F. Grace</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>John Mead</i>	Address <i>Chester, Md.</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332 X</i>		<i>Cerebral Thrombosis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<i>Cerebral Arterio sclerosis</i>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month, Day, Year <i>—</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
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ACTUAL SIGNATURE <i>Irvin G. Hoyt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>1/28/61</i>
EXAMINER'S NAME (Type) <i>Irvin G. Hoyt MD</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb. 1, 1961</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Cemetery</i>	22d. LOCATION (City, town, or county) <i>Woodlawn Maryland</i>	(State) <i>—</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward L. MacCost</i>	ADDRESS <i>Ellsworth Armacost 4600 Liberty Heights Ave.</i>	24a. REC'D BY REGISTRAR <i>EDP 1 61</i>	24b. REGISTRAR'S SIGNATURE <i>—</i>
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